Proceedings

GOVERNOR'S SEVENTH CONFERENCE ON THE HANDICAPPED

Indianapolis, Indiana — October 18-19, 1967

THE GOVERNOR'S SEVENTH CONFERENCE ON THE HANDICAPPED

Sponsored by

The Commission for the Handicapped
Indiana State Board of Health
Andrew C. Offutt, M.D.
State Health Commissioner

Cooperating Agencies

Indiana State Department of Public Welfare
State Department of Public Instruction
Division of Vocational Rehabilitation
Division of Special Education
Indiana Department of Mental Health
Indiana Employment Security Division

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GOVERNOR'S SEVENTH CONFERENCE ON THE HANDICAPPED

Indianapolis, Indiana — October 18-19, 1967

THEME:

"The Dilemma of Planning"

TRADES UNION COUNCIL 16

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Indiana State Board of Health
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Wednesday, October 18

STOUFFER'S INDIANAPOLIS INN

8:00 Registration—Lobby

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9:30 Opening General Session
Presiding: Mrs. Carolyn Tucker, Member, Commission for the Handicapped
Invocation: Daniel A. Gawronski, Ph.D. Supervisor, Counseling and Training, Indiana Division of Vocational Rehabilitation
Welcome: Ralph Phelps, Vice Chairman, Commission for the Handicapped, Indianapolis
A. C. Offutt, M.D., State Health Commissioner, Indianapolis
Keynote Address: Howard G. Lytle, L.H.D., Member, Commission for the Handicapped

10:30 Break

10:45 "Overview of Selected State Plans and How They Relate to You"
Robert O. Yoho, H.S.D., Assistant Commissioner for Administration, Indiana State Board of Health

12:00 Lunch

Afternoon Sessions: Windsor Room

1:30 "Impressions of State Planning"
Presiding: Ralph E. McDonald, D.D.S., Member, Commission for the Handicapped
PANEL
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Martin Meyer, Ed.D., Director, Division of Planning and Evaluation, Indiana Department of Mental Health
"Elementary and Secondary Education Act"
Cyrus Gunn, Director, Federal Projects Division, Indiana Department of Public Instruction.
"Comprehensive Health Planning"
Malcolm Mason, Director, Division of Health and Physical Education, Indiana State Board of Health
"Vocational Rehabilitation Planning"
Robert Davis, Project Director, Statewide Planning for Vocational Rehabilitation, Columbus, Ohio

2:30 Break

2:45 Concurrent Sessions
"Speak Your Mind"
Group Leaders:
Spiro B. Mitsos, Ph.D., Executive Director, The Rehabilitation Center, Evansville
Merrill C. Beyerl, Ph.D., Vice President, Ball State University, Muncie
Kenneth Chapman, Director, Community Service Council of Greater Indianapolis

4:30 Recess

Evening: Windsor Room

6:30 Banquet
Presiding: Ralph Phelps, Vice Chairman, Commission for the Handicapped
Invocation: Father Martin Peter, Pastor, St. Pius X Catholic Church
Entertainment: Melodyers, Arsenal Technical High School, Under the Direction of Miss Sandra Fanning.
Presentation of Governor's Rehabilitation Awards: A. C. Offutt, M.D., State Health Commissioner, on behalf of Governor Roger D. Branigin
Speaker: Newell C. Kephart, Ph.D., Professor of Education and Executive Director of the Achievement Center for Children, Purdue University
Address: "Learning Disabilities"

Thursday, October 19

Morning Session:

8:00-
10:00 Eye Opener Breakfast

Presiding: R. Leslie Brinegar, Member, Commission for the Handicapped

9:00 Invocation: Howard C. Lytle, L.H.D., Member, Commission for the Handicapped

Speaker: Harry B. Spanagel, Member, House of Representatives, State of Indiana, Lawrenceburg, Indiana

Subject: Progress Report on Legislative Committee To Study Problems of Multiply Handicapped

10:00 Break

10:15 Closing Session
Presiding: Gayle S. Eads, Member, Commission for the Handicapped

Subject: "Where Are We Going?"

Presentation of Resolutions by Group Leaders
Action on Resolutions by Assembly

12:00 Adjournment

Opening Remarks

RALPH N. PHELPS, *Vice-chairman*
Commission For The Handicapped
Indianapolis

This is an era of rapid change with increasing demands upon manpower, facilities and other resources. Time and obligations must be meshed in accord with priorities. Doctor Baxter, Chairman of the Commission, due to other commitments, is unable to be with us this morning. It is my privilege, as Vice-chairman of the Commission, to extend a welcome at this Seventh Annual Governor's Conference for the Handicapped.

With the inception of the Commission and even before, there was considerable interest in the problems of the handicapped. Through the efforts of interested individuals, private and special agencies and professional groups who came together to discuss and plan, progress has been achieved.

The impact of federal legislation has added greater emphasis to planning on a much broader scale. Currently, the charge of the Commission is the development of a master plan for rehabilitation services and facilities. A number of other state agencies have been given similar charges in their special area. As we meet here at this Governor's Seventh Conference for the Handicapped, considerations will be given to the total planning situation as it currently exists in Indiana.

It is with great pleasure that on behalf of the Commission for the Handicapped, I welcome you to this conference.

Welcome

A. C. OFFUTT, M.D.
State Health Commissioner
Indianapolis

It is a pleasure for me to join with you today and to share in your deliberations on "planning."

The tremendous advances in health during the past decade are indicative of the cooperative efforts of individuals, professions, organizations and the consumer to work toward a complete and effective rehabilitation program.

We must keep in mind that successful rehabilitation programs are built upon the interrelationship between medical, social, vocational and economic efforts.

Everyone who is engaged in providing for the welfare of human beings has the unavoidable responsibility of making others understand what he is trying to do.

There are many who express concern that we are facing a crisis in the provision of health care today, and, there is much evidence to indicate this is true. A greater concern for consumer interest and participation in all areas of health care is being demonstrated. Further, there is much concern for the organization of services on a more effective and efficient basis.

The most pressing dimension of our lives today is time, and changes are rapidly taking place as we are pressed to close the gap between the scientific advances in health care and its application.

Although planning has been occurring in rehabilitation over the years, we are faced with a responsibility of developing a more comprehensive plan for rehabilitation services and steps have already begun in the implementation of the development of a statewide plan for rehabilitation.

Concurrently with this, in my opinion, one of the most significant events in health is the amendment of the Public Health Service Act, P. L. 89-749, which provides for greater flexibility in the development of public health services.

More emphasis is placed on the development of health care services at the local level by the people who will best be able to determine the need, and greater emphasis is placed on planning for services on a more comprehensive basis.

I welcome you to the Seventh Annual Conference for the Handicapped.

Keynote Address

HOWARD G. LYTLE, *Director*
Indianapolis Goodwill Industries
Indianapolis

Mr. Chairman, Honored Members of the Commission for the Handicapped, and members of the Governor's Conference on the Handicapped—Ladies and Gentlemen:

One thing I have learned from some recent experiences: If you don't want a job, keep your mouth shut. Three times in the last three months I have suggested problems for discussion at conferences and each time I have been drafted to present the problem. I am sure that better presentations than mine could have been made on each of the three occasions. For this meeting, I tried to nail down a more effective method of the development of the idea involved, but I failed,

and as a result I am here to set the stage for our conference.

The general theme for our discussions here for the next day and a half has been phrased as, "The Dilemma of Planning." The theme came out of discussions within the program committee which looked at a number of issues in the field of programs for the handicapped in Indiana and discovered that somewhere between six and nine comprehensive state plans of service to the disabled are either developed, being developed, or contemplated. The Commission for the Handicapped itself is charged with working out a State plan for facilities and services for the handicapped. The creation of such a plan has been authorized by the Governor and a grant for financing the study has been received by the State Board of Health, within which the Commission functions.

Recent experience and current discussions in the field have presented several questions concerning this multiplicity of comprehensive plans for the sick and disabled. The very fact that six or eight such plans are needed raises doubt as to the comprehensiveness of any one of the plans. In my days as a student of philosophy I learned a dictum which is axiomatic in all philosophical discussion, known as "Occam's Razor," first enunciated by William of Occam. This is his statement: "Entities ought not to be multiplied beyond necessity." I would suggest its application to our field: "Comprehensive plans ought not to be multiplied beyond necessity." And I might add: "Neither should institutions."

A second question about these comprehensive plans arises from an experience we have recently had with an applicant for service at our own agency. I am using this one case as being not too unusual. The young man involved has been known to four agencies: a psychiatric treatment center, an institution for retarded, a medical-therapeutic facility, and a general welfare agency dealing with family problems. Each of these four agencies treated him for a specific condition for which it was set up. At least three of the agencies are involved in comprehensive planning for persons involved in specific difficulties. But nowhere in the case history is there any record of any referral by any of the four agencies to another agency to deal with another problem.

I used this incident as the basis of a discussion of team-work among agencies at the NRA meeting at Cleveland two weeks ago, and asked if the plight of the young man was unique. I was assured that he was caught in a common situation. One of the group suggested that in health and rehabilitation circles today the idea exists that, "If we could only get rid of the patients with complex problems, we could get on with the business of providing health services."

A third question comes from what is a reversal of current practice in the sheltered workshop field. For a number of years we have been developing special interest workshops: shops for the blind, shops for the retarded, shops for the emotionally ill, shops for the cerebral palsied, shops for paraplegics, shops for the tuberculous, and shops for a variety of special concerns. Now, in a number of shops for retarded, they are beginning to find that integration of the retarded into groups with other disabilities seems to produce better results in the vocational habilitation of the retarded than is achieved in the segregated shops. This may be true with other single disability shops. It may be equally true in other health, educational, and types of rehabilitation facilities. I raise the question whether comprehensive state plans for any special disability group may not be detrimental to a more adequate treatment of the problems of persons in that disability group.

The fourth question that comes to mind from some review of the comprehensive plans developed for special interest and special disability groups lies in the fact that our own experience indicates that professional personnel in these special interest groups frequently overlook or ignore health problems not closely related to their special interests. No indictment of a whole class of professionals in any group can be drawn up. However, enough specifics in our own experience can be cited to suggest the variety of needs of a given patient-client are not likely to be met in an institution geared to a special interest or disability. This is an issue that needs to be faced honestly and realistically in any comprehensive plan.

Now to get down to more specific issues. Again, let me make clear that I am not drawing up an indictment. I think we need plans—federal, state, regional, and community. I think equally that we need to ask the purpose of such plans. Do our plans for special disability groups tend to result in planning to establish, perpetuate and maintain our own specialized institutions and bureaucracy? Do we plan for the agency or do we plan for the patient-client? (The latter term is two nouns connected by a hyphen for this discussion, although there are those who question whether a more accurate statement might not make the first noun an adjective.) Every institution, once established to serve people, gradually becomes concerned about its own self-maintenance rather than the

service it is performing. This applies to government, the Church, and to social agencies. Power still corrupts.

There is no question but that one of our problems today is competition for funds available for health and welfare activities. Certainly some of our planning involves efforts to get a bigger piece of the pie for our own interests, which inevitably leaves less pie for other interests. One of the special interest groups recently boasted of getting Congress to rescind cuts in appropriations for its special program which, in the current tax and appropriation deadlock, simply means that someone else is going to get the axe. The action may have been fully justified. I am pointing out that the special interest group fought, possibly rightly, for its own special interest rather than with a full over-view of health and welfare needs of the total population.

Before any of you say to me, "You're another," I will admit it. Recently a paper was presented to a group in which there was an evaluation of our own institution's role in planning. I was amused, but brought up short, when the speaker suggested that we participated in "defensive" planning. How much of our planning *is* defensive rather than open-hearted planning for service?

Let me illustrate by some real situations. A year ago at our Conference in Terre Haute a program was proposed for certain of our state institutions. Several of us raised questions about standards for the program. We were firmly informed that the program was not subject to question by persons outside the particular group which was proposing it.

I think we are all aware that in various departments of government—at both the federal and state level—we are witnessing tugs-of-war over control of certain programs which carry with them certain substantial sums of money. To keep the illustration far from home, let's cite the competition for control of certain O.E.O. funds. But in any case, I raise the question as to whether the tug-of-war (wherever it exists) is over better service opportunities or over control of money with the power accompanying that control.

Again: some years ago a physician presented a paper to his professional peers in which he propounded the thesis that all rehabilitation procedures should be under the control of a physician. I do not know whether he understood the many facets of rehabilitation or not: vocational evaluation, work adjustment, training and placement. This may well have been the case. It may also have been that he wanted to assert the dominance of the medical profession in all aspects of treatment of a given individual. I do not know whether he has changed his mind since that date. I simply raise a question about a very human tendency, common to all of us, to equate our own interests with general welfare. Whether he said it or not, Engine Charlie's alleged statement, "What's good for General Motors is good for the country," typifies an attitude that creeps into the minds and hearts of all of us even if we are supposedly dedicated to service.

A corollary to the general issue involved here, and one that will have to be faced, is the question of case management of persons who are treated in institutions set up under these comprehensive plans. A report, made at the recent Conference of the National Rehabilitation Association at Cleveland, on research into habilitation of mentally retarded, made quite a point of the fact that when case management of a client was assigned to a staff member who was a professional therapist in any field, the results were less adequate than when case management was assigned to a generalist. This does not mean that the course of treatment given by a professional therapist was dictated by a generalist. It means that the generalist did have a broader view of the various professional therapies and secured more effective over-all treatment programs than did the specialist in one of the accepted therapies.

The problem is brought into focus when one considers the relationships between the resources of the community from which the "patient-client" comes and the specialized treatment institution to which the patient is referred, and from which he is released back into his local community and to some case management on the local level. Certainly, our planning needs to encompass the development of adequate resources in the appropriate community structure and a delineation of relationships between that structure and the larger institutions set up on a regional or statewide basis.

This naturally leads to some consideration in planning to the development of local community resources. These resources need to involve therapeutic services, social services, recreational services, economic services, educational services, and vocational services. Along with our comprehensive plans, some local community planning has to come.

The danger in community planning, however, lies in the fact of local community pride. Let me illustrate from the experience of one state in the matter of rehabilitation facilities. The original

state plan, developed under some pressures from local communities, included the location of at least one facility in every county of the state. Today the state would like to close thirty percent (30%) of these facilities. Overhead eats up too much of the available funds to make the cost-benefit ratio of the facility too high. But local pride stands in the way of the necessary consolidation of facilities on a regional basis and consequent reduction in number. Neither can the facilities in the smaller communities provide the variety of services needed. Adequate service at reasonable expense is denied "patient-clients" because local pride stands in the way.

All the issues I have raised previously with regard to planning—fragmentation and duplication of services, competition for funds, special interest pressures, and professional jealousies apply equally to community planning as they do to more so-called comprehensive planning.

Now we've looked at some problems. Where do we go? I don't have any answers at this moment. I do have three suggestions for exploration, however.

1. It may be that all this competition by special interest groups and institutions is good. The old cliche, "Competition is the life of trade," may be true here.

It may be that this competition stimulates improvement in quality of services in our field as it does in business. We can well find that a monolithic planning agency and institution will stifle initiative and expansion and imaginative thought by creating a monopoly in restraint of trade.

2. We have heard much and have had conferences about team-work among professionals. The team approach has been discussed, even though it may not always be practiced.

Isn't it time that we consider teamwork among agencies? What about cross-referrals between mental health facilities, special education programs, rehabilitation facilities, and local social services? And, to inject another issue, what about cross-referrals between certain of the Office of Economic Opportunity programs and existing health and rehabilitation facilities? How can we develop more adequate communication and co-ordination between the various specialized institutions so that the whole broad spectrum of services is made available to the person in need. You will recall the case of the young man whose multiple problems I cited earlier. The one continuum in that case is his mother who took him from one agency to another to try to get appropriate treatment for his many difficulties.

The Governor's Commission for the Handicapped is charged (among other things) with trying to coordinate services for the handicapped in the State. So far as I have observed, not one of the persons responsible for developing the state plans for special interest groups has ever asked the Commission for suggestions or consulted it about specific plans. I am not sure that the Commission has had either funds or staff to do much, if it had been consulted for suggestions, but I do know that consultation has been minimal at best. Members of the Commission have been told what was going on, but they have never been asked as to how one plan could mesh and dovetail with another. I cannot say how much cooperation there has been among authors of existing plans or authors of plans in the making with administrators of existing plans, but the need for such consultation and coordination is necessary if we are to avoid costly duplication and competition.

3. Whatever our planning may be, let us make sure we plan for the needs of a complex individual. We cannot break up a person into segments. We have made comprehensive state plans for agencies and institutions and specialized services. Do we have comprehensive plans for the individual? Can we develop a plan using various disciplines, services, agencies and institutions to serve a comprehensive person? This is our dilemma in planning.

Banquet Address

TEACHING THE CHILD WITH A HANDICAP

NEWELL C. KEPHART, Ph.D.,
Professor of Education, Executive Director of The Achievement Center For Childen, Purdue University

In a first grade classroom in Lafayette, there sits a youngster. He is a nice, clean-cut boy who is reasonably intelligent. He does not look any different than any of the other 29 children in this classroom. It does not matter what the rest of the class is doing, he seems to be doing something different. The teachers says he has a short attention span. The psychologist says he is distractible. Whenever there is a scuffle or fight on the playground, he always manages to be in the middle of it. The teacher says he is aggressive. The psychologist says he is socially imperceptive. He is given to quick fits of anger. The teacher

says he has a bad temper. The psychologist (who notices that his affectional responses are equally fleeting) says he is emotionally labile. He is frequently found wandering aimlessly in the corridors. The teacher says he doesn't care about school. The psychologist says he has a defective space structure. He *hates* drawing, copying, and coloring, but in the music hour he is right up front demonstrating for the group. The teacher says he is a showoff. The psychologist says he has disparities in ability.

His educational career is all too predictable. For the first three years he will muddle through. Every once in a while he will come up against something which he just cannot learn. After a while, however, he manages someway to get it. His performance on the whole is about average but the teacher cannot understand why he occasionally comes to these complete blocks. She tells the principal that he is something of a behavior problem and a "queer one." If you can "get to him," he can learn. In the lounge, she confesses to her fellow teachers that she thinks he is a little brat.

About the fourth grade, he will start to fail. Reports will begin to pour into the principal's office. "This child has not learned anything. He can't read. He can't write. How did he ever get to the fourth grade?" There will be a flurry of examinations. He will be given intelligence tests, educational tests, reading tests, personality tests until they are coming out of his ears. The compatibility of his parents will be investigated with the greatest detail. But nobody will uncover any reason for his failure. He will limp along falling further and further behind, advancing from grade to grade through social promotion until (if he does not drop out) he receives a high school diploma based on sheer perseverance.

This youngster suffers from a type of handicap which has only come to our attention in recent years. He is a child with a learning disorder. He is representative of 15 to 20 percent of the children in our school systems. His problem is that he does not see what we see; he does not hear what we hear; he does not experience in concrete situations what we experience. Therefore, the learning situations which we present him do not mean the same thing to him that they mean to us. When we think we are teaching him, we are presenting material which, to him, is irrelevant or distorted. The more complex our teaching materials, the more evident is his difficulty.

I do not wish tonight to dwell on the nature of learning disabilities. Excellent descriptions of the condition are appearing in the literature. I wish rather to consider learning disorder as a unique handicap. It is unique because of its nature—it is primarily an educational handicap. It is also unique because of its incidence—15 to 20 percent of the school population.

The school is being forced by very rapidly developing public concern to become cognizant of this handicap. Because of its unique features, it is forcing a re-examination of facilities for dealing with such children and thereby for dealing with all children with a handicap. Principles developing out of the problem of learning disorders appear applicable to all handicaps.

As has been pointed out, the child with learning disorders has specific problems which effect learning. Because of these problems, many of the customary presentations of the classroom may become meaningless to him. His is quite specifically an educational problem. Whereas other types of handicap interfere with educational procedures in certain ways, this child requires a whole different type of educational approach.

Special facilities have been provided in the public schools for children with handicaps. For the most part, these children have been segregated into groups determined by categories describing the most obvious handicapping condition. In general, these categories have been mutually exclusive. That is to say, the child is grouped according to his most obvious handicap. If he possesses two or more handicaps, a choice must be made and the child assigned to one class on the basis of this choice. Once having been assigned to this unitary classification, he is given the assistance appropriate to that particular handicap but receives little or no assistance with other handicaps which he may possess. Furthermore, these classifications are usually considered permanent. Thus, when a child has been classified, he remains in this category regardless of changes in his condition or changes in his academic performance.

The customary categories of special education are, for the most part, based on diagnostic findings of professions other than education. Thus the handicapping conditions identified by this means may be related to education but are not a part of education. An illustration is the category of physically handicapped. These children possess physical characteristics which make certain activities of the public school undesirable or impossible for them. Their learning behavior, however, is not changed. They learn in the same way and through the same procedures as do

other children. They require modifications of classroom procedures but not alterations of classroom presentation. The learning content and the learning presentations are as appropriate for these children as for any others. Their problems are medical not educational and the school's responsibility with reference to them is to preserve their medical welfare. From the point of view of the educational process, namely learning, they do not differ.

The blind and the deaf represent classifications of children in whom certain sensory avenues are not available for the transmission of information. Again, learning processes are not materially affected. Only certain areas of presentation must be avoided. These children require a modification of the curriculum which will omit presentations in the sensory areas which are disturbed and present this same material through one of the intact sensory areas. Basically, the presentations of the classroom are adequate, only certain ones have to be omitted. In addition, certain specialized techniques, such as braille or lip reading, must be introduced into the curriculum. These special techniques, however, can be taught through ordinary teaching techniques and are learned in essentially the same fashion as other learnings although the mechanics of the process may be somewhat different. Similar reasoning applies to other special education categories.

The current special education categories, therefore, involve conditions in which modifications of the teaching function are required to take into account certain problems of the child. Such modifications are extremely important and the provision of such special education classes is essential. These problems are not basically failures of the learning process, however, and hence relatively peripheral modifications of purely educational procedures are adequate.

The child with learning disorders, however, represents a handicap directly related to education. In this case, learning processes themselves are disturbed. Ordinary classroom presentations of materials do not suffice. His is basically an educational diagnosis and an educational handicap. For this child, a mere modification of teaching methods and techniques will not suffice. He requires an alteration of learning presentations.

For this reason, these children do not lend themselves to the same type of categorization representative of the classifications of special education as it functions today. Their problems strike at the heart of all education and present a challenge to all teaching. The overt manifestation of their problems are myriad. The specific factors which interfere with the learning of a particular task are multitude. The differences between what is presented and what is perceived cover a large gamut of specifics. For this reason, mere segregation does not insure homogeneous groups for teaching purposes. If such homogeneity could be achieved, a segregated, specialized facility could provide for their needs (as in the case of the physically handicapped). Since such homogeneity is not possible and since their difficulties cover the entire range of educational functions, the customary pattern of specialized facilities seems too narrow and too restricted to accommodate the many needs and many combinations of needs represented in the group of learning disorders.

In addition to being a truly educational classification, learning disorder is associated with higher than normal frequencies of other handicapping conditions. The same factors which gave rise to the learning disorder, frequently give rise to other problems as well. Thus, if the interference with learning is sufficiently wide spread and sufficiently intense, the child will be mentally retarded as well as a learning disorder. Educationally, he now needs a curriculum reduced in scope and sequence, but he also needs this reduced curriculum presented in an altered fashion. He requires educational procedures appropriate for mentally retarded and, at the same time, he needs educational procedures appropriate for the child with learning disorders.

If the neurological disorder strikes the proper area, the child is apt to display physical handicaps in addition to his learning problem. In like manner sensory impairment may be related to his overall condition.

Learning disorder cuts across the currently established categories. To establish a new category which will encompass those children with learning disorders but no other handicapping condition, is to artificially restrict children and the school's contribution to their educational needs. It means cutting the child to fit the category. Rather, it seems desirable to consider the needs of these children on the basis of their learning behavior and to provide for these needs wherever and whenever they occur throughout their school experience. Since their's is an educational handicap, it seems more appropriate to handle it as a problem of total education rather than as an educational sideline which may detract from rather than enhance the regular business of education. When

learning disorder is seen in this broader setting, it may provide the basis for better education for all handicapped children as well as that group which is its immediate concern.

The artificiality of our present special education categories for educational purposes is revealed when we consider a handicap which thus broadly cuts across many such artificial barriers. The dangers inherent in "hardening of the categories" is emphasized. The implied separation between special education and general education seems even more hazardous than it has seemed in the past.

It would appear that three types of facility should be provided to cover adequately the range and complexity of the problems of these children.

Classroom management. A large number of such children have interferences with learning which are relatively limited. Although the difficulty which they display is probably in itself maximal, it extends over a very limited area of learning. It would appear that, when an interference exists, its effect is largely "all-or-none."

Such interference, however, may be limited to a relatively small number of classroom activities.

Children whose difficulties are thus limited have more to gain from association with their peers in the classroom and more to gain from the bulk of classroom presentations which are not interfered with, than they do from intensive treatment of their problems in isolation. It is, therefore, felt that such children should be dealt with in the regular classroom situation and should not be segregated from their peers.

To handle such problems in the classroom, however, suggests the need for information on the part of the classroom teacher. This teacher should know enough about such problems to be able to observe them in classroom situations and be able to investigate such observed behaviors from the point of view of the effects of possible learning disorders. He needs to know enough to make a screening diagnosis for purposes of referral or of suggested alterations in classroom procedure for this child.

In addition to information concerned with identification, the classroom teacher should have information concerning the more obvious and less complex procedures for training pertinent for the most common difficulties encountered with such children.

Since learning disorders are so wide spread in the pupil population, *every* classroom teacher will come in contact with these problems.

With such upgrading of professional skills among teachers, a large number of handicapped children can be handled adequately within the regular classroom environment. It is desirable that they be handled in this manner since their problems do not set them off from their peers sufficiently to warrant more drastic procedures. Furthermore, such retention within the classroom maintains the basic relationship to education represented by these difficulties and encourages an attack upon them which is educationally based.

I foresee the day when no beginning teacher will be certified without a basic understanding of handicaps of children and their effect upon education and learning: not only learning disorders but *all* handicaps. I foresee the day when no practicing teacher will be permitted to retain his job without demonstrating a basic ability to deal with children with minor handicaps.

Such an eventuality will require a new look at the problem of continuing education. The day when a student could complete a four year course at a teacher training institution and thereby obtain all the information he required for a lifetime of teaching has long since gone. More continuous and better planned contacts with institutions of higher learning are required. Furthermore (and perhaps more importantly, every school system should maintain an organized, concerted program of inservice training. Such inservice training should serve to update the teaching staff on educational methods and procedures. It should also evaluate the isoteric findings of educational research and development to make them applicable to the local problems of the local school district.

Among the most important areas for such training for years to come will be the rapidly developing field of teaching the child with a handicap.

Clinical Procedures. A second group of children with learning disorders have problems that are somewhat more extensive or which somewhat more intensively interfere with processes considered important in the classroom. Such children tend to fall increasingly behind in classroom activities. Their difficulties are frequently severe in the total skills and hence they consistently interfere with a large number of presentations. The result is that such children slip further and further behind unless they receive special attention for their specific problems. This gradual loss of achievement is disturbing to the child and further interferes with his progress. He, therefore, tends to display an increase in problems as time goes on.

These children would appear to profit from an intensive but limited therapeutic attack upon their

specific problems. Such an attack can best be provided through a clinical approach. The model for such a program could well be the speech correction program provided by many school systems. In such a program the child is removed from the classroom for scheduled periods of therapy in small groups or in individual contacts with the therapist. At the end of the therapeutic session, he returns to his classroom.

For these moderately severe problems, such a facility seems desirable. Because of their evident difficulty in the classroom and their own awareness of this difficulty, the effect of stigma attached to special attention to problems is reduced so that their difficulties are not magnified by special treatment. At the same time, they learn so much from association with their peers and from the bulk of classroom presentations that it is not feasible to remove them permanently from the classroom environment. The short term, intensive treatment period can frequently relieve their problem sufficiently to permit them to once again keep up with their class.

I foresee the day when all types of therapeutic facilities will be available either in the school or in connection with the school. Such complete facilities are already available in many school systems. Too often, however, the child must be segregated in a special class or special school in order to avail himself of them. Such an administrative procedure permits the tail to wag the dog. The child is subjugated to his handicap.

In severe cases, as we will see in a moment, such segregation may be necessary. In less severe cases it is neither feasible nor desirable. What is needed is an extension of such clinical facilities so that they may be available for all children who need them in a form which will adapt itself to the needs of the child. Then the educational problem of adjusting the total child to his environment can remain predominant and therapeutic procedures can serve this overall objective.

Obviously, such an extension of therapeutic practices will await a much more intensive and much more continuous inter-disciplinary dialogue than is currently occurring.

Special classes. There will remain in the school system a number of children whose interference with learning is so extensive that normal classroom procedures are largely impossible for them. Furthermore, this interference is so intensive that it seems probable that these children will require specialized educational presentations for the rest of their school experience or at least for a major portion of it. These "hard core cases" have little to gain from normal classroom experiences since these presentations are so confusing to them that they intensify rather than reduce their problems.

For such children, the special room seems appropriate. In such a room, specialized learning situations are presented and intensive attacks are made upon the learning disorders. Frequently, educational aims and objectives with respect to curriculum need to be revised in view of the probable limited attainment of basic skills by this group.

This last group of children would appear to fit the requirements of the customary special education approach. The customary procedure of a special room where this group is segregated from their peers for intensive specialized treatment for relatively long periods of time seems appropriate.

Such special classes, however, should be kept flexible. Where changes in learning ability occur, provision should be made for transfer of the child into one of the other facilities for dealing with his learning disorder. Every effort should be made to return him, whenever possible, to the main stream of education. The activities of this classroom should be based on the child's learning requirements — not on his etiological categorization. When this is true, methods appropriate to various categories can be combined and integrated to serve the needs of the total child.

When such segregation occurs, care must be taken to insure that the overall objectives of education are not lost. How frequently does the school administration, which is responsible for over-all objectives, disclaim any responsibility for the child once he has been assigned to a special room? In our concern with the child's handicap, we must not lose sight of his education. In our preoccupation with the question, "How can we teach this child?", we must not forget to also ask, "Why am I teaching him?" Too often we have assumed that anything in the regular curriculum which we can teach is all to the good. Frequently, this procedure leads to a smattering of disconnected skills and knowledges which contribute little to the child's adjustment to his environment. The curriculum of the special class needs to be carefully scrutinized in terms of the overall objectives of education. Teaching for teaching's sake is not enough. Unless the total learning contributes to the child's welfare, we waste our time.

In summary, the problem of the child with learning disorders is forcing education to deal with certain questions in the education of the handicapped. The answers to these questions may well influence the future of education for all handi-

capped. In particular the need appears to be for (1) more flexibility in defining the educational needs of the handicapped, (2) a marked extension of services beyond the group of hard core cases to children with lesser degrees of handicap, (3) a closer liaison between education of the handicapped and general education with more attention to the basic aims and objectives of education.

In the past ten years we have learned a great deal about educating a handicap. This preliminary and necessary step has been accomplished on the whole very well. It is now time to move on to the next step: the application of this knowledge to the needs of the child. We know a great deal about how to teach to a handicap. We must now learn how to teach a *child* with a handicap.

Panel Discussions

THE ELEMENTARY AND SECONDARY EDUCATION ACT OF 1965 (PUBLIC LAW 89-10)

CYRUS GUNN, *Director*
Federal Projects Division
Indiana Department of Public Instruction

Although Federal Aid to Education in the United States is not new, the Elementary and Secondary Education Act of 1965 is distinctive in that the federal government recognized, in a major way, the national responsibility for education and the federal government as a junior partner in this enterprise. In this Act the greatest single appropriation for education in the history of the nation was passed providing for categorical aid to the elementary and secondary schools. These funds were provided on a nonmatching basis and, save for general federal guidelines providing for the use of the funds for the purposes specified and fiscal accounting, local school districts were left with considerable discretionary powers in the use of the funds. In all cases the funds were designed to supplement state and local funds but not to supplant them. The various Titles of the Elementary and Secondary Education Act provided for the following:

Title I—aid to the states for the education of the educationally deprived, that is, the poor, the handicapped, the neglected, and the delinquent.

Title II—assistance to the local schools for the purchase of library books and other instructional materials.

Title III—funds for the establishment of supplementary services and centers and for the initiation of exemplary and innovative practices in education.

Title IV—establishment of regional research laboratories on an inter-state basis to spearhead changes in education in the states involved.

Title V—funds to the State Departments of Public Instruction for the purpose of strengthening the states to increase their ability to give leadership to educational improvement in the states.

In 1967, Title VI was added to the Elementary and Secondary Education Act providing aid to states for the establishment of programs of instruction for handicapped children and for the establishment of a Bureau for the Handicapped in the U. S. Office of Education.

Titles IV and V were not direct aid to the improvement of elementary and secondary education but they were expected to contribute indirectly to this end. Title II, which provided for library books and materials, though given directly to school districts, was designed to contribute to the improvement of the educational program by furnishing materials to be used in the educational process.

More directly, as far as health and welfare services are concerned, Titles I, III, and VI are most significant, and these are the Titles to which we will direct our attention.

Although the complete picture, as it is developing, will not be known for some time and the impact assessed, it is not too early to point out that sixty percent of approximately four hundred school corporations had some provision for health and social services in their Title I programs. These include social services related to attendance, health services related to physical and mental health, and food services. Included in these programs were 130 nurses, 78 speech correctionists, 31 teachers of the mentally retarded, 20 psychologists, 11 teachers of the emotionally disturbed, nine dentists, three teachers of the physically handicapped, and three teachers of the mentally handicapped.

Of the 30 Title III projects approved by the United States Office of Education for Indiana in the first year of the operation of the Act, six or 20 percent of the projects included some provision for health services. These varied widely in type and scope from the four-county guidance consortium at Bedford to the diagnostic and treatment center in Vigo County.

More recently Title III programs have been projected for remedial and clinical services to children with learning and emotional problems in

connection with the Madison State Hospital at Madison; the work-oriented program for educationally handicapped youth at Marion; and psychological services at Bicknell.

Although Title VI has been added to the Elementary and Secondary Education Act by Amendment in 1967, it has not as yet been funded to any significant extent. However, a State Plan for Indiana for the use of funds in this Title when they become available in greater amount is being formulated by the Division of Special Education. It is expected that substantial sums will be appropriated for this Title in the future.

In general, the main thrust of the Elementary and Secondary Education Act of 1965 and its amendments is to provide money over and above local budgets to encourage new approaches to persistent educational problems, to strengthen the State Departments of Public Instruction in order that they may provide stronger leadership in the charting of the direction for education in the states, and to aid the local school districts in moving more rapidly toward the solution of the educational problems of the nation.

INDIANA STATE COMPREHENSIVE HEALTH PLAN

MALCOLM MASON, *Director*
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Indiana State Board of Health
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Those involved in the administration of health programs have become increasingly aware of the fractionalization of services available to the public. Part of the reason for this situation has been the individual rather than a coordinated agency approach to planning. The individual approach invites duplication of effort and/or omissions of service and invariably leads to complete frustration and confusion; no choice remains other than the development of a planning procedure that guarantees consideration of all problems and all resources that can be marshaled to make available the solution to these problems in an organized manner.

Comprehensive planning is not a newly discovered concept. There is much evidence to substantiate the values gained from sound planning. In many areas and on many occasions, utilizing a multiagency approach, comprehensive planning has been accomplished in local communities resulting in an improved quality and quantity of health services to the public.

We might ask, what are we considering in comprehensive planning?

1. Preventive Medicine.
2. Manpower and Training.
3. Hospital Facilities and Services.
4. Rehabilitation Facilities and Services.
5. Water Quality.
6. Air Pollution.
7. Mental Health.
8. Mental Retardation.

Planning has taken place in many of these categories and the basic job ahead is to examine the needs of the state and to establish priorities for meeting these needs. This will require intra-agency planning as well as community planning wherein the public agencies, voluntary and official, participate.

The following is a brief summary of Public Law 89-749:

The Governor of the State of Indiana on January 6, 1967, informed our State Health Commissioner that the Indiana State Board of Health had been delegated and appointed as the single state agency responsible for administering and supervising the state health planning functions, especially those provided for under Public Law 89-749, Comprehensive Health Planning, or sometimes referred to as Partners For Health.

The State Board of Health has submitted to the Surgeon General a state plan and upon approval will be eligible to receive funds for administering the plan. The budget includes funds for a Director of Planning, Analyst, Community Planning Specialist and Clerk, honorarium for planning council members, contractural services, and consultant fees.

Voluntary health agencies and local service organizations, as well as individuals selected for their special fitness and capabilities are being contacted concerning the establishment of a State Health Planning Council. These organizations are being requested to submit names of people whom they wish to have considered. It is anticipated that the council will be composed of approximately fifty members, of which the majority shall be consumers of health.

Objectives

1. To increase the capacity for continuing comprehensive planning for health.
2. To redirect the focus of grant programs to revitalize state and local health efforts and to focus on the delivery of services to people.

Expected Results

1. From planning—a foundation for rational and efficient use of all health resources.
2. From flexibility—the allocation of resources according to state or local needs in order to bring about a greater impact on the health of the people.

Planning

314 (a) Formula Grants for Comprehensive State Health Planning
—Calls for State Health Planning Agency
—Calls for State Health Planning Council

314 (b) Project Grants for Area-Wide Planning
—To support comprehensive regional, metropolitan, or other local area planning
—Replaces area-wide facilities planning grants authorized under Section 318

314 (c) Project Grants for Training, Studies, and Demonstrations
—To support training, etc., related to comprehensive health planning

Health Services

314 (d) Formula Grants for Public Health Services
—Distributed on mathematical basis to States (to be used in accordance with comprehensive health plans)
—No earmarking for categorical programs, this is a block grant
—Provides for local and voluntary agency participation

314 (e) Project Grants for Health Services Development
—To meet health needs of limited geographic scope or of special regional or national significance; to stimulate new programs; or for studies, demonstrations or training to develop new methods, etc.

There are many questions for which there are no answers. This is as it should be, for a lack of knowledge and sense of direction are the bases for the need for sound legislation.

Thus, I am sure that comprehensive planning will require that we be more tolerant and understanding, establish better lines of communication, and develop more respect for the opinions of others.

Splinter groups can only weaken our efforts. Reform, if needed, must come from within. Comprehensive planning, I believe, presents a supreme test for all of us interested in the health and well-being of our total population.

COMPREHENSIVE VOCATIONAL REHABILITATION PLANNING (EXCERPTS)

ROBERT DAVIS, *Project Director*
Ohio Comprehensive Planning For
Vocational Rehabilitation

I do not consider myself to be a professional planner. My last assignment was in Vietnam and I was in and out of Vietnam for the past seven years. I was there as director of an educational technical assistance program and developed this program over a number of years. I developed, what I call, indispensable qualities there that are serving very well in comprehensive statewide planning for vocational rehabilitation. I think I should mention these. The first one is operating under fire—being shot at a few times. The second one is that I finally learned the wisdom of considering myself to be expendable. The third thing is to work in the midst of what seems to be extensive and massive confusion.

In Ohio we are well into our second year of comprehensive planning. As a matter of fact, we are coming down to the wire—in some places we have crossed over the wire. We've been pushed over the wire. We have had 87 percent increase in referrals in the state bureau of vocational rehabilitation. They say statewide planning has been shaking the trees and the bushes and the people are flocking in for services that they never realized existed before. This of course causes financial and staff problems. In fact, we are going to have some very severe public relations problems as a result of things going on in Ohio right now. So what this means is that we are having to turn our timetable all around and where we were planning rather comfortably to move into legislation and finance in about six or eight months, we are in a crash program right now of trying to gear up our governor's council and to try to find ways of infusing large additional appropriations into the state program. Things are happening as a result of comprehensive planning in Ohio.

Over 700 citizens are involved and we have representation from nearly all 88 counties in the state. The citizens are now turning in their preliminary recommendations and are calling for broad expansion of vocational rehabilitation services not only to what we term the disabled physically and mentally but the disadvantaged popula-

tion including those who are now restless and unproductive in the city ghettos and in Appalachia. The state is going to have to realize that they need the talents, the productivity, the consumer powers and the tax dollars of those that are now dependent. The key citizens in the statewide planning now concluding this study share the conviction that rehabilitation must be given high priority if many of the underlying problems of public dissent and unrest are to be substantially alleviated. In other words, a goal to get people employed if possible, at least occupied, in remunerative productive activity. In addition to the physically disabled, the rehabilitation techniques can now benefit the mentally retarded, emotionally ill, the alcoholic, the drug addict, the public offender and the educationally and economically deprived. Newer approaches are being tried to reach these individuals in urban and rural poverty settings. Recent federal legislation and reorganization of federal and state service departments provide new flexibility both for funding and innovated programming. Such legislation mirrors a growing awareness that society can no longer afford merely to support its disadvantaged citizens. So we have the amendment to the vocational rehabilitation act of 1965 which brought about the organizing of comprehensive statewide planning in about 50 states and territories.

Our objective in problems of statewide planning is not just to look and see what the incidence of disability happens to be or to cover particular disabilities in the state. We do need to know the size of the problem—who needs to be served. We've come up with a very conservative figure which is 2.1 percent of the population. We could say 12 or 13 percent but we don't want to scare people to death so we've cut it way down and we talk about people who we feel are eligible and feasible for services in vocational rehabilitation. We came up with a gap looking something like this. Last year in Ohio, 3,698 clients were successfully rehabilitated on the job. We have a population of 10,600,000 in Ohio, with 230,000 people considered to be eligible for services. A program of expansion of about five fold (as soon as we can get the funds) is the expansion factor which we have set in Ohio.

I would like to just mention briefly the way we have gone about gathering data and making recommendations and formulating a comprehensive statewide plan. I just want you to know not as an example of what could be done but what is being done in Ohio. Our policy board is called the governor's council. We have executive committees of four of the 22 members of the council. We have a central planning staff which consists of a project director, a director of research, and the administrative officer who manages the total statewide coordination of planning operations with seven full-time staff people in seven planning regions around the state. That is, we have seven full-time staff executive secretaries to regional business committees. The key people in state-wide planning in Ohio are these citizens who are the regional citizens committee chairmen. We have task forces on physical disabilities, mental disabilities, special disabilities which includes the educationally and economically culturally deprived, public offenders, alcoholic and drug addicts, etc. We have one on manpower, facilities and workshops (which is intermeshed with the workshop and facilities planning) and also one on interagency coordination. I can't stress too much the importance of this interagency coordinating committee which seeks to interrelate the planning operation at a local and state level.

The seventh task force is on plans. We are moving into our final stages of comprehensive planning and will be taking all of these chairmen and pulling them into the state office. We will then have an ad hoc committee on physical difficulties which will look at all seven regional plans together. And look at the comparisons, the gaps, etc., and then we'll make recommendations to all the task forces. The same plan will be followed on universal manpower. There will be delegates of these ad hoc committees on mental, physical, social manpower that will go into our statewide ad hoc committee on the master plan and will take all of these 7 regional plans which will remain intact and be working documents for the different planning levels locally. They will take those seven master plans and pull out a statewide comprehensive master plan and will then prepare the necessary abstracts and working documents to present to the governor and the legislature. We find that we are doing a lot of implementing as we move along and one thing that we did not intend to get into was the matter of financial appropriations. But, we happen to figure that we have a very real crisis now financially and this can be turned to benefit the Department of Vocational Rehabilitation program in Ohio if we can use it to get the legislature and executive office to see the need for additional appropriations—we are authorized about $22 million dollars for Ohio, a combination of state and federal funds, and we are only using 8 million. We want to get after that problem in a hurry.

Awards

Public Personnel Award

The Public Personnel Award may be presented to an individual employed in a public agency located in the State of Indiana. The award is to honor a person who has earned public recognition for outstanding contributions in facilitating employment of the handicapped in his or her agency.

Mr. Harold Zeis, Mayor of the City of Fort Wayne, is being so honored tonight for his role in employing male clients from Fort Wayne State Hospital and Training Center in carrying out a plan to clean up and beautify many miles of untended river banks in the Fort Wayne area.

This activity known as River Bank Project has served the dual purpose of giving clients of the institution an opportunity to be employed in a competitive community work setting and has also served to educate the community to the vocational abilities of the retarded.

The project began in the spring of 1964 with 10 clients for a two-week period. By 1967, a total of 92 different individuals had been employed. Age range was from 17 to 55 years, functioning levels within the low-moderate to mildly retarded intellectual ranges, and they had been institutionalized from 3 to 27 years.

For his support and cooperation in making the project a success it is a pleasure to present a Public Personnel Award to Mr. Harold Zeis.

Employer's Merit Awards

The next category is that of Employer's Merit Award. This Award may be made to any employer in business or industry having an outstanding record of employment of the handicapped.

It is hoped that the presentation of this award will serve to demonstrate to other employers that it is ability—not disability that determines the value of the employee.

This year, two Indiana employers are being honored for their efforts in this area. The first of these employers is Creative Packaging, Inc., of Indianapolis. This company has, for many years, followed an "equal rights" policy toward handicapped workers. Currently included in their work force are victims of polio, laryngectomy, mental retardation and deaf mutes. Approximately one out of twenty employees is a deaf mute. Types of jobs held by handicapped persons in this company range from laborer to computer programmer. Wages, fringe benefits, promotions and transfer policies apply to handicapped employees on the same basis as to all other employees. It is my pleasure to present this award to *Mr. John S. Bryan,* director of Administration, for Creative Packaging, Inc.

The second Employer's Merit Award goes to Mr. Sam Levin, of Levin and Sons, Inc., of Fort Wayne. As a result of Mr. Levin's efforts his company since 1963, has provided employment for 60 mentally retarded individuals from the Fort Wayne Hospital and Training Center. Eighty percent of those so employed are now living and working outside the institutional environment. The periods of institutionalization were from 8 months to 25 years and all were functioning in the moderate to mildly retarded range of intelligence. I am happy to present this award to *Mr. Sam Levin.*

The Governor's Trophy

The Governor's Trophy may be awarded each year as a special honor to a handicapped Hoosier who has surmounted his or her own handicap and who has helped to encourage and inspire or facilitate the employment of other handicapped persons.

This year the trophy is being awarded to a man who is a casualty of World War II. As an army demolition specialist, he lost both hands and arms and the use of his left leg while attempting to defuse a land mine on a roadway in Italy.

At the time of his entrance into military service, he was considered one of the finest prospects for a professional baseball career to ever come out of southern Indiana. Upon his return home from military service, he became active in civic affairs particularly those having programs for youth. For the past several years he has organized and assisted in various athletic activities for disadvantaged children. He coaches both baseball and basketball for one of the local schools.

Eight years ago he offered his services in whatever capacity he could serve to the Joseph Rauch Center for the Retarded, a school for trainable children. About a year later a workshop was constructed and he volunteered to organize and plan a program for the children. Today he is workshop supervisor. He has been instrumental in laying the groundwork for acceptance of the retarded as workers in the community. He has served in a consulting capacity to the local office of the Vocational Rehabilitation Division in the placement of mentally retarded clients. With the assistance of this Division, the Arts and Crafts Shop of the

George Tinius

Center has become a prevocational and on-the-job training facility.

His impact on the community is attested to by local government officials, representatives of the news media, civic and fraternal organizations, and representatives of the professions and private business.

In 1960, he received the Distinguished Community Service Award from Redmen Tribe #276 of New Albany in recognition of his help in developing programs for the youth of Floyd County. In 1964, the Hobart Beach Veterans of Foreign Wars annual "Outstanding Citizen" award was given in recognition of and appreciation for outstanding service in instructing handicapped and retarded children to become active, useful citizens. The first annual "St. John Bosco Award" of the New Albany Deanery, highest award given in the Catholic Church for Catholic Youth Organization activities was given him in 1967 for outstanding services to youth.

He is married, the father of two sons and a daughter, who follows her father's footsteps in working with the handicapped.

It is very gratifying to be able to present the Governor's Trophy to George, or as he is better known by many, "Tooter" Tinius—Handicapped Hoosier of 1967, from New Albany, Indiana.

COMMITTEE REPORTS AND RECOMMENDATIONS

Committee to Study the Problems of the Multiply Handicapped

Harry B. Spanagel, member of the Indiana House of Representatives from Lawrenceburg, served as replacement for Sandor Levin, Michigan State Senator, who was unable to appear due to legislative commitments in his home state.

Representative Spanagel pointed out that a Committee to Study the Problems of the Multiply Handicapped was created by the 1967 Legislature and that the Committee is now functioning in this area. He went on to say that so far, the Committee has started work through appointing subcommittees to:

1. Determine the feasibility of setting up a central registry so there will be an overall list of such cases and background. If set up, it will be done by authority so that such information must be reported properly.

2. Research present laws on the statutes to determine what we already have for reporting handicapped so that these laws may be amended or substituted by one all inclusive measure.

3. Research to find the name and background information of all agencies and voluntary organizations in the State of Indiana having any interest in work pertaining to the handicapped, i.e., officers, address, purpose, fund sources, etc.

4. Find out what other states have done or plan to do to further resolve the problems of the multiply handicapped.

5. Define or re-define the proper definition of a handicapped person.

It was further indicated that these projects are now being worked upon by the Committee and it is hoped there will be further developments in the near future.

Recommendations

The format for the Governor's Seventh Annual Conference on the Handicapped called for a presentation of the problems of planning by selected agency representatives followed by smaller group

discussions. It was hoped that some general and specific recommendations would come out of these discussions which might isolate problems and their solutions or at least point out desired directions for the state to move.

The group discussions did produce a wide variety of comments and they ranged from general observations to specific recommendations covering issues of statewide concern. The best method of presentation of these points would appear to be in the form of brief summary statements with no attempt to place them in order of priority or make editorial comment.

Group Leaders and Recorders
Dr. Mitsos and George Hufford
Dr. Beyerl and Allen Heuss
Kenneth Chapman and John Helme

— If planning is to be effective it must be a grassroots movement. It must have the support of the political policy makers and it must make them aware of the needs of the handicapped.

— The Commission for the Handicapped was created for the purpose of accomplishing many of the things discussed at this conference. The Commission should be given the staff and the support to do the job that the legislature mandated it to do.

— In planning for services for the handicapped, high priority must be given to the development of an effective system of communications and referral within agencies and between agencies and services.

— In planning for services for the handicapped, greater emphasis must be given to helping the handicapped person reach maximum independence according to his ability both in private and in sheltered employment situations.

— There is an urgent need for the definition of regions both inter-state and intra-state if we are to ever accomplish meaningful coordination of planning.

— Guidelines, standards and policies must be established and enforced for the operation of sheltered workshops.

— A state register of the handicapped is becoming increasingly important. Many of the problems of planning in departments and agencies throughout the state are directly related to the problem of incidence and prevalence.

— A priority system is becoming an essential part of the planning effort. We need to establish a well defined system of priorities which cuts across the fields of medical service and rehabilitation and insures quality, not quantity, programs.

— Any agency or training facility accepting handicapped persons for services has the responsibility to follow through for that person.

— There is a need at the state level for administrative organization sufficient to give overall direction to the many and varied planning projects. Herein should be the authority for coordination, integration, regionalization and whatever else may be needed to make these plans truly comprehensive and workable.

— Greater emphasis should be placed upon research efforts and the application of principles suggested by completed research.

— Some plan or program needs to be devised for those individuals who are unable to profit from gainful employment whereby they too can retain their self-respect.

— Concern for the problems of the handicapped must be demonstrated by the highest level of state administration. We as citizens must voice our opinions to these powers.

— Planning should be done according to need rather than sources of revenue or income.

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